

Has the Drug-Based Approach to Mental Illness Failed?

Journalist Robert Whitaker is more concerned than ever that psychiatric medications do more harm than good

By John Horgan on October 17, 2020

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One of the most impressive, disturbing works of science journalism I've encountered is *Anatomy of an Epidemic: Magic Bullets, Psychiatric Drugs, and the Astonishing Rise of Mental Illness in America*, published in 2010. In the book, which I review here, award-winning journalist Robert Whitaker presents evidence that medications for mental illness, over time and in the aggregate, cause net harm. In 2012, I brought Whitaker to my school to give a talk, in part to check him out. He struck me as a smart, sensible, meticulous reporter whose in-depth research had led him to startling conclusions. Since then, far from encountering persuasive rebuttals of Whitaker's thesis, I keep finding corroborations of it. If Whitaker is right, modern psychiatry, together with the pharmaceutical industry, has inflicted iatrogenic harm on millions of people. Reports of surging mental distress during the pandemic have me thinking once again about Whitaker's views and wondering how they have evolved. Below he answers some questions. —John Horgan

Horgan: When and why did you start reporting on mental health?

Whitaker: It came about in a very roundabout way. In 1994, I had co-founded a publishing company called CenterWatch that covered the business aspects of the "clinical trials industry," and I soon became interested in writing about how financial interests were corrupting drug trials. Risperdal and Zyprexa had just come to market,

and after I used a Freedom of Information request to obtain the FDA's review of those two drugs, I could see that psychiatric drug trials were a prime example of that corruption. In addition, I had learned of NIMH-funded research that seemed abusive of schizophrenia patients, and in 1998, I co-wrote a series for the Boston Globe on abuses of patients in psychiatric research.

My interest was in that broader question of corruption and abuse in research settings, and not specific to psychiatry.

At that time, I still had a conventional understanding of psychiatric drugs. My understanding was that researchers were making great advances in understanding mental disorders, and that they had found that schizophrenia and depression were due to chemical imbalances in the brain, which psychiatric medications then put back in balance. However, while reporting that series, I stumbled upon studies that didn't make sense to me, for they belied what I knew to be "true," and that was what sent me down this path of reporting on mental health.

First, there were two studies by the World Health Organization that found that longer-term outcomes for schizophrenia patients in three "developing" countries were much better than in the U.S. and five other "developed" countries. This didn't really make sense to me, and then I read this: in the developing countries, they used antipsychotic drugs acutely, but not chronically. Only 16 percent of patients in the developing countries were regularly maintained on antipsychotics, whereas in the developed countries this was the standard of care. That didn't fit with my understanding that these drugs were an essential treatment for schizophrenia patients.

Second, a study by Harvard researchers found that schizophrenia outcomes had declined in the previous 20 years, and were now no better than they had been in the first third of the 20th century. That didn't fit with my understanding that psychiatry had made great progress in treating people so diagnosed.

Those studies led to my questioning the story that our society told about those we call "mad," and I got a book contract to dig into that question. That project turned into *Mad in America*, which told of the history of our society's treatment of the seriously mentally ill, from colonial times until today—a history marked by bad science and societal mistreatment of those so diagnosed.

Horgan: Do you still see yourself as a journalist, or are you primarily an activist?

Whitaker: I don't see myself as an "activist" at all. In my own writings, and in the webzine I direct, *Mad in America*, I think you'll see journalistic practices at work, albeit in the service of an "activist" mission.

Here is our mission statement: "Mad in America's mission is to serve as a catalyst for rethinking psychiatric care in the United States (and abroad). We believe that the current drug-based paradigm of care has failed our society, and that scientific

research, as well as the lived experience of those who have been diagnosed with a psychiatric disorder, calls for profound change.”

Thus, our starting point is that “change” is needed, and while that does have an activist element, I think journalism—serving as an informational source—is fundamental to that effort. As an organization, we are not asserting that we have the answers for what that change should be, which would be the case if we were striving to be activists. Instead, we strive to be a forum for promoting an informed societal discussion about this subject.

Here’s what we do:

We publish daily summaries of scientific research with findings that are rarely covered in the mainstream media. You’ll find, in the archives of our research reports, a steady parade of findings that counter the conventional narrative. For instance, there are reports of how the effort to find genes for mental disorders has proven rather fruitless, or of how social inequalities trigger mental distress, or of poor long-term outcomes with our current paradigm of care. And so forth—we simply want these scientific findings to become known.

We regularly feature interviews with researchers and activists, and podcasts that explore these issues.

We launched MIA Reports as a showcase for our print journalism. We have published in-depth articles on promising new initiatives in Europe; investigative pieces on such topics as compulsory outpatient treatment; coverage of “news” related to mental health policy in the United States; and occasional reports on how the mainstream media is covering mental health issues.

We also publish blogs by professionals, academics, people with lived experience, and others with a particular interest in this subject. These blogs and personal stories are meant to help inform society’s “rethinking” of psychiatric care.

All of these efforts, I think, fit within the framework of “journalism.”

However, I do understand that I am going beyond the boundaries of usual “science journalism” when I publish critiques of the “evidence base” related to psychiatric drugs. I did this in my books *Mad in America* and *Anatomy of an Epidemic*, as well as a book I co-wrote, *Psychiatry Under the Influence*. I have continued to do this with MIA Reports.

The usual practice in “science journalism” is to look to the “experts” in the field and report on what they tell about their findings and practices. However, while reporting and writing *Mad in America*, I came to understand that when “experts” in psychiatry spoke to journalists they regularly hewed to a story that they were expected to tell, which was a story of how their field was making great progress in understanding the biology of disorders and of drug treatments that—as I was told over and over when I co-wrote the series for the *Boston Globe*—fixed chemical imbalances in the brain. But their own science, I discovered, regularly belied the story they were telling to the media. That’s why I turned to focusing on the story that could be dug out from a critical look at their own scientific literature.

So what I do in these critiques—such as suicide in the Prozac era and the impact of antipsychotics on mortality—is review the relevant research and put those findings together into a coherent report. I also look at research cited in support of mainstream beliefs and see if the data, in those articles, actually supports the conclusions presented in the abstract. None of this is really that difficult, and yet I know it is unusual for a journalist to challenge conventional “medical wisdom” in this way.

Horgan: *Anatomy of an Epidemic* argues that medications for mental illness, although they give many people short-term reliefs, cause net harm. Is that a fair summary?

Whitaker: Yes, although my thinking has evolved somewhat since I wrote that book.

I am more convinced than ever that psychiatric medications, over the long term, cause net harm. I wish that weren’t the case, but the evidence just keeps mounting that these drugs, on the whole, worsen long-term outcomes.

However, my thinking has evolved in this way: I am not so sure any more that the medications provide a short-term benefit for patient populations as a whole. When you look at the short-term studies of antidepressants and antipsychotics, the evidence of efficacy in reducing symptoms compared to placebo is really pretty marginal, and fails to rise to the level of a “clinically meaningful” benefit.

Furthermore, the problem with all of this research is that there is no real placebo group in the studies. The placebo group is composed of patients who have been withdrawn from their psychiatric medications and then randomized to placebo. Thus, the placebo group is a drug-withdrawal group, and we know that withdrawal from psychiatric drugs can stir myriad negative effects. A medication-naïve placebo group would likely have much better outcomes, and if that were so, how would that placebo response compare to the drug response?

In short, research on the short-term effects of psychiatric drugs is a scientific mess. In fact, a 2017 paper that was designed to defend the long-term use of antipsychotics nevertheless acknowledged, in an off-hand way, that “no placebo-controlled trials have been reported in first-episode psychosis patients.” Antipsychotics were introduced 65 years ago, and we still don’t have good evidence that they work over the short term in first episode patients. Which is rather startling, when you think of it.

Horgan: Have any of your critics—E. Fuller Torrey, for example—made you rethink your thesis?

Whitaker: When the first edition of *Anatomy of an Epidemic* was published (2010), I knew there would be critics, and I thought, this will be great. This is just what is needed, a societal discussion about the long-term effects of psychiatric medications.

I have to confess that I have been disappointed in the criticism. They mostly have been ad hominem attacks—I cherry-picked the data, or I misunderstood findings, or I am just biased, but the critics don’t then say what data I missed, or point to findings that tell of medications that improve long-term outcomes. I honestly think I could do a much better job of critiquing my own work.

You mention E. Fuller Torrey’s criticism, in which he states that I both misrepresented and misunderstood some of the research I cited. I took this seriously, and answered it at great length.

Now if your own “thesis” is indeed flawed, then a critic should be able to point out its flaws while accurately detailing what you wrote. If that is the case, then you have good reason to rethink your beliefs. But if a critique doesn’t meet that standard, but rather relies on misrepresenting what you wrote, then you have reason to conclude that the critic lacks the evidence to make an honest case. And that is how I see Torrey’s critique.

For example, Torrey said that I misunderstood Martin Harrow’s research on long-term outcomes for schizophrenia patients. Harrow reported that the recovery rate was eight times higher for those who got off antipsychotic medication compared to those who stayed on the drugs. However, in his 2007 paper, Harrow stated that the better outcomes for those who got off medication was because they had a better prognosis and not because of negative drug effects. If you read *Anatomy of an Epidemic*, you’ll see that I present his explanation.

Yet, in my interview with Harrow, I noted that his own data showed that those who were diagnosed with milder psychotic disorders who stayed on antipsychotics fared worse over the long term than schizophrenia patients who stopped taking the medication. This was a comparison that showed the less ill maintained on antipsychotics doing worse than the more severely ill who got off these medications. And I presented that comparison in *Anatomy of an Epidemic*.

By doing that, I was going out on a limb: I was saying that maybe Harrow's data led to a different conclusion than he had drawn, which was that the antipsychotic medication, over the long-term, had a negative effect.

After *Anatomy* was published, Harrow and his colleague Thomas Jobe went back to their data and investigated this very possibility. They have subsequently written several papers exploring this theme, citing me in one or two instances for raising the issue, and they found reason to conclude that it might be so. They wrote: "How unique among medical treatments is it that the apparent efficacy of antipsychotics could diminish over time or become harmful? There are many examples for other medications of similar long-term effects, with this often occurring as the body readjusts, biologically, to the medications."

Thus, in this instance, I did the following: I accurately reported the results of Harrow's study and his interpretation of his results, and I accurately presented data from his research that told of a possible different interpretation. The authors then revisited their own data to take up this inquiry. And yet Torrey's critique is that I misrepresented Harrow's research.

This same criticism, by the way, is still being flung at me. Here is a recent article in *Vice* which, once again, quotes people saying I misrepresent and misunderstand research, with Harrow cited as an example.

I do want to emphasize that critiques of "my thesis" regarding the long-term effects of psychiatric drugs are important and to be welcomed. See two papers in particular that take this on ([here](#) and [here](#)), and my response in general to such criticisms, and to the second one.

Horgan: When I criticize psychiatric drugs, people sometimes tell me that meds saved their lives. You must get this reaction a lot. How do you respond?

Whitaker: I do hear that, and when I do, I reply, "Great! I am so glad to know that the medications have worked for you!" But of course I also hear from many people who

say that the drugs ruined their lives.

I do think that the individual's experience of psychiatric medication, whether good or bad, should be honored as worthy and "valid." They are witnesses to their own lives, and we should incorporate those voices into our societal thinking about the merits of psychiatric drugs.

However, for the longest time, we've heard mostly about the "good" outcomes in the mainstream media, while those with "bad" outcomes were resigned to telling their stories on internet forums. What Mad in America has sought to do, in its efforts to serve as a forum for rethinking psychiatry, is provide an outlet for this latter group, so their voices can be heard too.

The personal accounts, of course, do not change the bottom-line "evidence" that shows up in outcome studies of larger groups of patients. Unfortunately, that tells of medications that, on the whole, do more harm than good.

As a case in point, in regard to this "saving lives" theme, this benefit does not show up in public health data. The "standard mortality rate" for those with serious mental disorders, compared to the general public, has notably increased in the last 40 years.

Horgan: Do you see any promising trends in psychiatry?

Whitaker: Yes, definitely.

You have the spread of Hearing Voices networks, which are composed of people who hear voices and offer support for learning to live with voices as opposed to squashing them, which is what the drugs are supposed to do. These networks are up and running in the U.S., and in many countries worldwide.

You have Open Dialogue approaches, which were pioneered in northern Finland and proved successful there, being adopted in the United States and many European countries (and beyond.) This practice puts much less emphasis on treatment with antipsychotics, and much greater emphasis on helping people re-integrate into family and community.

You have many alternative programs springing up, even at the governmental level.

Norway, for instance, ordered its hospital districts to offer “medication free” treatment for those who want it, and there is now a private hospital in Norway that is devoted to helping chronic patients taper down from their psychiatric medications. In Israel, you have Soteria houses that have sprung up (sometimes they are called stabilizing houses), where use of antipsychotics is optional, and the environment—a supportive residential environment—is seen as the principal “therapy.”

You have the U.N. Special Rapporteur for Health, Dainius Pūras, calling for a “revolution” in mental health, one that would supplant today’s biological paradigm of care with a paradigm that paid more attention to social justice factors—poverty, inequality, etc.—as a source of mental distress.

All of those initiatives tell of an effort to find a new way. But perhaps most important, in terms of “positive trends,” the narrative that was told to us starting in the 1980s has collapsed, which is what presents the opportunity for a new paradigm to take hold.

More and more research tells of how the conventional narrative, in all its particulars, has failed to pan out. The diagnoses in the Diagnostic and Statistical Manual (DSM) have not been validated as discrete illnesses; the genetics of mental disorders remain in doubt; MRI scans have not proven to be useful; long-term outcomes are poor; and the notion that psychiatric drugs fix chemical imbalances has been abandoned. Ronald Pies, the former editor in chief of *Psychiatric Times*, has even sought to distance psychiatry, as an institution, from ever having made such a claim.

Horgan: Do brain implants or other electrostimulation devices show any therapeutic potential?

Whitaker: I don’t have a ready answer for this. We have published two articles about the spinning of results from a trial of deep-brain stimulation, and the suffering of some patients so treated over the long-term. Those articles tell of why it may be difficult to answer that question: there are financial influences that push for published results that tell of a therapeutic success, even if the data doesn’t support that finding, and we have a research environment that fails to study long-term outcomes.

The history of somatic treatments for mental disorders also provides a reason for caution. It’s a history of one somatic treatment after another being initially hailed as curative, or extremely helpful, and then failing the test of time. The inventor of frontal lobotomy, Egas Moniz, was awarded a Nobel Prize for inventing that surgery, which today we understand as a mutilation.

It's important to remain open to the possibility that somatic treatments may be helpful, at least for some patients. But there is plenty of reason to be wary of initial claims of success.

Horgan: Should psychedelic drugs be taken seriously as treatments?

Whitaker: I think caution applies here too. Surely there are many risks with psychedelic drugs, and if you were to do a study of first-episode psychosis today, you would find a high percentage of the patients had been using mind-altering drugs before their psychotic break—antidepressants, marijuana, LSD and so forth. At the same time, we've published reviews of papers that have reported positive results with use of psychedelics. What are the benefits versus the risks? Can possible benefits be realized while risks are minimized? It is a question worth exploring, but carefully so.

Horgan: What about meditation?

Whitaker: I know that many people find meditation helpful. I also know other people find it difficult—and even threatening—to sit with the silence of their minds. Mad in America has published reviews of research about meditation, we have had a few bloggers write about it, and in our resource section on “non-drug therapies,” we have summarized research findings regarding its use for depression. We concluded that the research on this is not as robust as one would like.

However, I think your question leads to this broader thought: People struggling with their minds and emotions may come up with many different approaches they find helpful. Exercise, diet, meditation, yoga and so forth all represent efforts to change one's environment, and ultimately, I think that can be very helpful. But the individual has to find his or her way to whatever environmental change that works best for them.

Horgan: Do you see any progress toward understanding the causes of mental illness?

Whitaker: Yes, and that progress might be summed up in this way: researchers are returning to investigations of how we are impacted by what has “happened to us.”

The Adverse Childhood Experiences study provides compelling evidence of how traumas in childhood—divorce, poverty, abuse, bullying and so forth—exact a long-term toll on physical and mental health. Interview any group of women diagnosed with a serious mental disorder, and you'll regularly find accounts of sexual abuse. Racism

exacts a toll. So too poverty, oppressive working conditions, and so forth. You can go on and on, but all of this is a reminder that we humans are designed to respond to our environment, and it is quite clear that mental distress, in large part, arises from difficult environments and threatening experiences, past and present.

And with a focus on life experiences as a source of “mental illness,” a related question is now being asked: what do we all need to be mentally well? Shelter, good food, meaning in life, someone to love and so forth—if you look at it from this perspective, you can see why, when those supporting elements begin to disappear, psychiatric difficulties appear.

I am not discounting that there may be biological factors that cause “mental illness.” While biological markers that tell of a particular disorder have not been discovered, we are biological creatures, and we do know, for instance, that there are physical illnesses and toxins that can produce psychotic episodes.

However, the progress that is being made at the moment is a moving away from the robotic “it’s all about brain chemistry” toward a rediscovery of the importance of our social lives and our experiences.

Horgan: Do we still have anything to learn from Sigmund Freud?

Whitaker: I certainly think so. Freud is a reminder that so much of our mind is hidden from us and that what spills into our consciousness comes from a blend of the many parts of our mind, our emotional centers and our more primal instincts. You can still see merit in Freud’s descriptions of the id, ego and superego as a conceptualization of different parts of the brain. I read Freud when I was in college, and it was a formative experience for me.

Horgan: I fear that American-style capitalism doesn’t produce good health care, including mental-health care. What do you think?

Whitaker: It’s clear that it doesn’t.

First, we have for-profit health-care that is set up to treat “disease.” With mental-health care, that means there is a profit to be made from seeing people as “diseased” and treating them for that “illness.” Take a pill! In other words, American-style capitalism, which works to create markets for products, provides an incentive to

create mental patients, and it has done this to great success over the past 35 years.

Second, without a profit to be made, you don't have as much investment in psychosocial care that can help a person remake his or her life. There is a societal expense, but little corporate profit, in psychosocial care, and American-style capitalism doesn't lend itself to that equation.

Third, with our American-style capitalism (think neoliberalism), it is the individual that is seen as "ill" and needs to be fixed. Society gets a free pass. This too is a barrier to good "mental health" care, for it prevents us from thinking about what changes we might make to our society that would be more nurturing for us all. With our American-style capitalism, we now have a grossly unequal society, with more and more wealth going to the select few, and more and more people struggling to pay their bills. That is a prescription for psychiatric distress. Good "mental health care" starts with creating a society that is more equal and just.

Horgan: How might the COVID-19 pandemic affect care of the mentally ill?

Whitaker: That is something Mad in America has reported on. The pandemic, of course, can be particularly threatening to people in mental hospitals, or in group homes.

The threat is more than just the exposure to the virus that may come in such settings. People who are struggling in this way often feel terribly isolated, alone, and fearful of being with others. COVID-19 measures, with calls for social distancing, can exacerbate that. I think this puts hospital staff and those who run residential homes into an extraordinarily difficult position—how can they help ease the isolation of patients even as they are being expected to enforce a type of social distancing?

Horgan: If the next president named you mental health czar, what would be at the top of your To Do list?

Whitaker: Well, I am pretty sure that's not going to happen, and if it did, I would quickly confess to my being utterly unqualified for the job. But from my perch at Mad in America, here is what I would like to see happen in our society.

As you can see from my answers above, I think the fundamental problem is that our society has organized itself around a false narrative, which was sold to us as a

narrative of science. In the early 1980s, we began to hear that psychiatric disorders were discrete brain illnesses, which were caused by chemical imbalances in the brain, and that a new generation of psychiatric drugs fixed those imbalances, like insulin for diabetes. That is a story of an amazing medical breakthrough: researchers had discovered the very chemicals in our brain that cause madness, depression, anxiety or ADHD, and they had developed drugs that could put brain chemistry back into a normal state. Given the complexity of the human brain, if this were true, it would arguably be the greatest achievement in medical history.

And we understood it to be true. We came to believe that there was a sharp line between the “normal” brain and the “abnormal” brain, and that it was medically helpful to screen for these illnesses, and that psychiatric drugs were very safe and effective, and often needed to be taken for life.

But what can be seen clearly today is that this narrative was a marketing story, not a scientific one. It was a story that psychiatry, as an institution, promoted for guild purposes, and it was a story that pharmaceutical companies promoted for commercial reasons. Science actually tells a very different story: the biology of psychiatric disorders remains unknown; the disorders in the DSM have not been validated as discrete illnesses; the drugs do not fix chemical imbalances but rather perturb normal neurotransmitter functions; and even their short term efficacy is marginal at best.

As could be expected, organizing our thinking around a false narrative has been a societal disaster: a sharp rise in the burden of mental illness in our society; poor long-term functional outcomes for those who are continuously medicated; the pathologizing of childhood; and so on.

What we need now is a new narrative to organize ourselves around, one steeped in history, literature, philosophy, and good science. I think step one is ditching the DSM. That book presents the most impoverished “philosophy of being” imaginable. Anyone who is too emotional, or struggles with his or her mind, or just doesn’t like being in a boring environment (think ADHD) is a candidate for a diagnosis. We need a narrative that, if truth be told, can be found in literature. Novels, Shakespeare, the Bible—they all tell of how we humans struggle with our minds, our emotions and our behaviors. That is the norm; it is the human condition. And yet the characters we see in literature, if they were viewed through the DSM lens, would regularly qualify for a diagnosis.

At the same time, literature tells of how humans can be so resilient, and that we change as we age and move through different environments. We need that to be part of a new narrative too; our current disease-model narrative tells of how people are likely going to be chronically ill. Their brains are defective, and so the therapeutic goal

is to manage the symptoms of the “disease.” We need a narrative that replaces that pessimism with hope.

If we embraced that literary understanding of what it is to be human, then a “mental health” policy could be forged that would begin with this question: how do we create environments that are more nurturing for us all? How do we create schools that build on a child’s curiosity? How do we bring nature back into our lives? How do we create a society that helps provide people with meaning, a sense of community, and a sense of civic duty? How do we create a society that promotes good physical health, and provides access to shelter and medical care?

Furthermore, with this conception in mind, individual therapy would help people change their environments. You could encourage walks in nature; recommend volunteer work; provide settings where people could go and recuperate, and so forth. Most important, in contrast to a “disease-based” paradigm of care, a “wellness-based” paradigm would help people feel hopeful, and help them find a way to create a different future for themselves. This is an approach, by the way, that can be helpful to people who have suffered a psychotic episode. Soteria homes and Open Dialogue are “therapies” that strive to help psychotic patients in this manner.

Within this “wellness” paradigm of care, there would still be a place for use of medications that help people feel differently, at least for a time: sedatives, tranquilizers, and so forth. And you would still want to fund science that seeks to better understand the many pathways to debilitating mood states and to “psychosis”—trauma, poor physical health, physical disease, lack of sleep, setbacks in life, isolation, loneliness, and yes, whatever biological vulnerabilities that may be present. At the same time, you would want to fund science that seeks to better understand the pillars of “wellness.”

Horgan: What’s your utopia?

Whitaker: My “utopia” would be a world like the one I just described, based on a new narrative about mental illness, rooted in an understanding of how emotional we humans are, of how we struggle with our minds, and of how we are built to be responsive to our environments. And that really is the mission of Mad in America. We want it to be a forum for creating a new societal narrative for “mental health.”